PRINTED: 08/04/2009

FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING С B. WING \_ NVS297AGC 06/29/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4462 FARMCREST DRIVE

PARADISE CREST HOME CARE		4462 FARMCREST DRIVE LAS VEGAS, NV 89121					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
Y 000	Initial Comments	Y 000					
	The findings and conclusions of any investigat by the Health Division shall not be construed a prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal state, or local laws.	as					
	This Statement of Deficiencies was generated a result of a complaint investigation conducted your facility on 6/29/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.	l in					
	The facility is licensed for ten Residential Facil for Group beds for elderly and disabled person and/or persons with mental retardation. The census at the time of the survey was nine. Nin resident files were reviewed and four employe files were reviewed. The facility received a gra of D.	e e					
	Complaint #NV00022386was substantiated. S Tag Y878	See See					
	The following deficiencies were identified:						
Y 105 SS=E	449.200(1)(f) Personnel File - Background Che	eck Y 105					
	NAC 449.200  1. Except as otherwise provided in subsection a separate personnel file must be kept for each member of the staff of a facility and must inclur (f) Evidence of compliance with NRS 449.176 449.185, inclusive.	h de:					
	This Regulation is not met as evidenced by: Based on record review on 6/29/09, the facility	,					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
CONTROL						
	NVS297AGC		B. WING			C <b>29/2009</b>
OVIDER OR SUPPLIER	INVOLUTACIO	STREET ADD	RESS, CITY, STA	ATE. ZIP CODE	1 00/	23/2003
CREST HOME CARE				_		
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		,	1710	DEFICIENCY)		
Continued From page	e 1		Y 105			
failed to ensure 1 of 4	4 caregivers met backg	round				
	_	ks				
and an initial physica	l).					
Severity: 2 Scope:	2					
440 200(2)(a) Porson	and File 1st aid 8 CDI	<b>o</b>	V 106			
449.200(2)(a) Persor	illei File - 15t alu & CFr	`	1 100			
NAC 449.200						
residential facility must include, in addition to the information required pursuant to subsection 1,						
cardiopulmonary resu	uscitation.					
,						
-						
#9 residents.	additation (Of Tt), and of	ing an				
Severity: 2 Scope:	3					
449 2175(4) Service	of Food - Special Diets		V 273			
1 70.2 17 0(7) DEI VICE	on rood - opecial Diets		. 270			
NAC 449.2175						
		uea a				
	CORRECTION  OVIDER OR SUPPLIER  E CREST HOME CARE  SUMMARY ST (EACH DEFICIENCE REGULATORY OR  Continued From page failed to ensure 1 of a check requirements (finger prints, state and an initial physical severity: 2 Scope:  449.200(2)(a) Person  NAC 449.200 2. The personnel file residential facility multinformation required (a) A certificate stating currently certified to particular currently certified to enforce the facility failed to enfor	NVS297AGC  OVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUREGULATORY OR LSC IDENTIFYING INFORMAT)  Continued From page 1  failed to ensure 1 of 4 caregivers met backg check requirements (Employee #3 was miss finger prints, state and FBI background check and an initial physical).  Severity: 2 Scope: 2  449.200(2)(a) Personnel File - 1st aid & CPF  NAC 449.200  2. The personnel file for a caregiver of a residential facility must include, in addition to information required pursuant to subsection (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation.  This Regulation is not met as evidenced by Based on interview and record review on 6/2 the facility failed to ensure that 1 of 4 employ (Employee #3) completed training in first aid cardiopulmonary resuscitation (CPR), affectified to perform first aid cardiopulmonary resuscitation (CPR), affectified to ensure that 2 of 4 employ (Employee #3) completed training in first aid cardiopulmonary resuscitation (CPR), affectified to ensure that 2 of 4 employee #3 of 449.2175 (4) Service of Food - Special Diets  NAC 449.2175  4. A resident who has been placed on a special completed training in first aid cardiopulmonary resuscitation (CPR).	NVS297AGC  OVIDER OR SUPPLIER  E CREST HOME CARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  failed to ensure 1 of 4 caregivers met background check requirements (Employee #3 was missing finger prints, state and FBI background checks and an initial physical).  Severity: 2 Scope: 2  449.200(2)(a) Personnel File - 1st aid & CPR  NAC 449.200  2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation.  This Regulation is not met as evidenced by: Based on interview and record review on 6/29/09, the facility failed to ensure that 1 of 4 employees (Employee #3) completed training in first aid and cardiopulmonary resuscitation (CPR), affecting all #9 residents.  Severity: 2 Scope: 3  449.2175(4) Service of Food - Special Diets  NAC 449.2175  4. A resident who has been placed on a special diet by a physician or dietitian must be provided a meal that complies with the diet. The	TOURISH OF THE PROPERTY OF DEFICIENCY AND STREET ADDRESS, CITY, STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION)  Continued From page 1  failed to ensure 1 of 4 caregivers met background check requirements (Employee #3 was missing finger prints, state and FBI background checks and an initial physical).  Severity: 2 Scope: 2  449.200(2)(a) Personnel File - 1st aid & CPR  NAC 449.200  2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation.  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CITY, STATE, ZIP CODE  4462 FARMCREST DRIVE  4462 FARMCREST DRIVE  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST are PRECEDED by FULL  RESULATORY OR LSC IDENTIFITING INFORMATION)  PREFIX  TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION & FORMATION)  PREFIX  TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION & FORMATION)  PREFIX  TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION & FORMATION)  PREFIX  TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION & FORMATION)  PREFIX  TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION & FORMATION)  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION & FORMATION)  PROVIDERS PLAN OF CORRECTION (EACH C

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		NVS297AGC		B. WING		06/29/2	2009
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	-	
PARADISE	E CREST HOME CARE			ICREST DRIVI S, NV 89121	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULSC IDENTIFYING INFORMAT	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
Y 273	physician or dietitian 90 days.  This Regulation is not Based on observation the facility failed to prof 2 residents on a sp. #9).  Severity: 2 So	cation to the menu to ecial diets prescribed by are kept on file for at lest met as evidenced by an and interview on 6/29 rovide a low sodium die becial diet (Resident #8 cope: 3	ast : :/09, t to 2	Y 273			
Y 274 SS=C	NAC 449.2175 5. Any substitution for be documented and least 90 days after substitution must be place during the service.  This Regulation is not based on observation the facility failed to enwere documented and days.	or an item on the menusept on file with the menusept on file with the menusept on file with the substitution occurs posted in a conspicuousice of the meal.  of met as evidenced by an and interview on 6/29 asure menu substitution d retained for at least 9 ope: 3	nu for . A s .	Y 274			
Y 530 SS=C	449.260(1)(e) Activiti	es for Residents		Y 530			

		(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		NVS297AGC		B. WING		06/29/2	2009
NAME OF PROVIDER OR SUPPLIER STREET				RESS, CITY, STA	ATE, ZIP CODE		
PARADISE CREST HOME CARE				ICREST DRIV S, NV 89121	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
Y 530	` '	sidents at least 10 hour led activities that are su		Y 530			
	Based on interview a the facility failed to er each week that were interests and capaciti		/09, ties				
	Severity: 1 Scope:	3					
Y 557 SS=D	449.262(3)(a) Restric	tion on Use of Restrain	ts	Y 557			
	NAC 449.262 3. The members of tr facility shall not: (a) Use restraints on	ne staff of a residential any resident.					
	Based on observation	ot met as evidenced by: n on 6/29/09, the facility ed rails were not being	<i>,</i>				
	Severity: 2 Scope:	1					
Y 876 SS=B	NAC 449.2742 4. Except as otherwis subsection, a caregiv administration of med	se provided in this		Y 876			
	caregiver may assist	_	`				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	NVS297AGC			A. BUILDING B. WING		C 06/29/2009	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE. ZIP CODE	1 00/2	.0,2000
DADADISE COEST HOME CADE			4462 FARI	ICREST DRIV S, NV 89121			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
Y 876	Continued From page	e 4 s or dangerous drugs o	nly if	Y 876			
		ibed in subsection 6 of					
	Based on record review failed to ensure that a	ot met as evidenced by ew on 6/29/09, the facil an ultimate user agreen 9 residents (Resident	ity nent				
	Severity: 1 Scope:	2					
Y 878 SS=D	449.2742(6)(a)(1) Me	edication / Change orde	er	Y 878			
	the physician. If a ph the amount or times r administered to a res	ation prescribed by a Iministered as prescribe hysician orders a chang medication is to be ident: ponsible for assisting ir medication shall:	e in				
	Based on record revirfailed to ensure that a medications as preson Bactroban 2% cream applied to the affecte MAR was only signed.	ot met as evidenced by ew on 6/29/09, the facil 1 of 9 residents receive cribed (Resident #3). I was prescribed to be d area 3 times a day. d for 6/15/09 in the am, 18/09 in the am, 6/22/0	ity d Γhe				

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

06/29/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER  PARADISE CREST HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE  4462 FARMCREST DRIVE  LAS VEGAS, NV 89121					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI	JLL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
Y 878	Continued From page 5  the am and 6/23/09 in the am. Senna plus to was a discrepancy between the doctors order what was on the bottle and what was written the MAR. The facility failed to administer PF medications to 1 of 9 residents (Resident #3 prescribed. PRN medications were given routinely.  Severity: 2 Scope: 1	here ers, i on RN	Y 878				
Y 885 SS=D	NAC 449.2742  9. If the medication of a resident is discontin the expiration date of the medication of a resident who has been discharged from the facility does not claim the medication, an employee of a residential facts shall destroy the medication, by an acceptate method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuar NAC 449.2744. Flushing contents of vials, bottles or other containers into a toilet shall to deemed to be an acceptable method of destruction of medication.	ued, sident ne sility ble	Y 885				
	This Regulation is not met as evidenced by: Based on observation on 6/29/09, the facility failed to ensure medications for 1 of 9 reside were destroyed (Resident #3). Ultram and E were both discontinued by the doctor, and the bottles were still in the residents box. Temazepam and Haldol prescription strength were changed and the old prescriptions were in the resident's medication box.	y ents Bentyl ne					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

PRINTED: 08/04/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS297AGC 06/29/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4462 FARMCREST DRIVE PARADISE CREST HOME CARE LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 885 Y 885 Continued From page 6 Severity: 2 Scope: 1 Y 920 449.2748(1) Medication Storage Y 920 SS=F NAC 449 2748 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by: Based on observation on 6/29/09, the facility failed to ensure that medications belonging to 9 of 9 residents were secured (Resident #1, #2, #3,

#4, #5,#6, #7, #8 and #9).

Severity: 2 Scope: 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED C			
		NVS297AGC		B. WING		06	6/29/2009	
NAME OF PROVIDER OR SUPPLIER  PARADISE CREST HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE  4462 FARMCREST DRIVE LAS VEGAS, NV 89121					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FI PR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
Y 930	Continued From pa	nge 7		Y 930				
Y 930 SS=C	449.2749(1)(a) Res	sident File		Y 930				
	1. A separate file management of a resident of a resident least 5 years after larger facility. The file muthat is resistant to funauthorized use. records, letters, assinformation and anythe resident, including	nust be maintained for ea ential facility and retained ne permanently leaves the list be kept locked in a platifier and is protected again. The file must contain all sessments, medical by other information relate ing without limitation: address, date of birth and other of the resident.	for at e ace ast					
	Based on observat failed to ensure 9 o	not met as evidenced by ion on 06/29/09, the facili if 9 (Resident #1, #2, #3, #9) resident files were ke	ty #4,					
	Severity: 1 Scop	e: 3						
Y 936 SS=F	449.2749(1)(e) Res	sident file		Y 936				
	resident of a reside least 5 years after I facility. The file mu that is resistant to f unauthorized use. records, letters, ass information and any the resident, includ (e) Evidence of cor	nust be maintained for ea ential facility and retained ne permanently leaves th list be kept locked in a pla ire and is protected agair The file must contain all sessments, medical y other information relate ing without limitation: inpliance with the provisions	for at e ace ast d to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			(X2) MULTIP  A. BUILDING  B. WING	LE CONSTRUCTION	I	ted C	
				RESS, CITY, STA		06/2	29/2009
PARADISE CREST HOME CARE				ICREST DRIV S, NV 89121	=		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
Y 936	Based on record review failed to ensure 2 of 9	ereto.  ot met as evidenced by: ew on 6/29/09, the facil 9 residents complied widing tuberculosis testing ) which affected all	ity th	Y 936			
Y 953 SS=D	449.275(3)(a)(b) Hos	pice Care		Y 953			
	to NAC 449.2736 by residential facility tha residential facility ma (a) Is bedfast, as defi	ats a request made purs the administrator of a t provides hospice care y retain a resident who: ined in NAC 449.2702. tursing or other medical	, the				
	Based on interview a the facility failed to ap	ot met as evidenced by: nd observation on 6/29, oply for a waiver to reta on hospice and is bedfa	/09, in 1				